



UNITED STATES OF AMERICA



OCT 10 1995

FEDERAL TRADE COMMISSION
Washington, DC 20580

DEPARTMENT OF JUSTICE
Washington, DC 20530

The Honorable Pete Stark
Member of Congress
U.S. House of Representatives
Washington, D.C. 20515

Dear Representative Stark:

The Federal Trade Commission and the Department of Justice (the "Agencies") are writing in response to your letters of October 4, 1995, requesting the Agencies' comments on two antitrust provisions of the "Medicare Preservation Act of 1995," H.R. 2425. The Administration supports the increased availability of provider networks to promote competition and expand competitive choices for consumers. Further, the Administration believes that legislative reforms, which include appropriate consumer protection safeguards, are necessary to achieve this goal. The Federal Trade Commission has taken no position on aspects of Medicare reform other than the comments in this letter on the two antitrust provisions of H.R. 2425.

However, the two antitrust provisions in H.R. 2425, which would create a broad antitrust exemption for medical self-regulatory entities and would substantially relax the antitrust treatment of provider service networks, are unnecessary and inappropriate. First, the antitrust exemption for medical self-regulatory entities would allow plainly anticompetitive conduct that is harmful to consumers. Second, unlike the provider service organizations, in which the members will share financial risk and therefore have strong incentives to provide health care services more efficiently, there is no risk-sharing requirement associated with provider service networks. These two antitrust provisions are unnecessary to protect any legitimate activity; would immunize a broad range of anticompetitive activities that could harm consumers and raise health care costs; and could seriously undermine the cost containment goals of Medicare reform efforts. The Agencies urge that these provisions not be adopted.

I. ANTITRUST EXEMPTION FOR MEDICAL SELF-REGULATORY ENTITIES

Section 15221 of H.R. 2425 would immunize medical groups' setting or enforcing of "standards" that are "designed to promote the quality of health care services provided to patients," unless the activity is "conducted for the purposes of financial gain" or "interferes" with practice by a "provider who is not a member of the specific profession subject to the authority of the medical self-regulatory entity." If enacted, this provision would establish a broad exemption that could open the door for anticompetitive activity engaged in by physicians, including boycotts, price-fixing, and other conduct that is plainly anticompetitive and harmful to consumers. This exemption, which extends well beyond actions taken in connection with the Medicare program, is not necessary to protect legitimate self-regulatory activity, and could severely jeopardize efforts to control health care costs.

A. The Proposed Exemption Would Immunize a Broad Range of Anticompetitive Conduct Harmful to Consumers

The proposed exemption would immunize activities by medical societies and hospital medical staffs to establish and enforce standards for "professional conduct" (Sec. 15221 (c)(6)(D)). The Agencies are concerned that medical societies have used "professional conduct" standards to impose blanket bans on procompetitive alternatives to traditional fee-for-service medicine -- including physicians' employment by HMOs and "lay" hospitals, affiliation with non-physicians, and engaging in truthful advertising -- based on an assertion that these activities inherently lead to lower quality of care. See e.g., American Medical Assn, 94 F.T.C. 701, 1011-13, 1017 (1979), aff'd, 638 F.2d 443 (2d Cir. 1980), aff'd by an equally divided Court, 455 U.S. 676 (1982) (ethical rules against salaried employment, working for "inadequate compensation," and affiliating with non-physicians found anticompetitive).

Although antitrust law enforcement actions have successfully challenged such ethical rules by national medical societies, subsequent enforcement actions of reflect continuing actions of medical self-regulatory bodies to obstruct efforts to promote cost-effective delivery of health care services. For example, the Agencies have acted to prevent medical societies, medical staffs, and other physician groups from:

- * boycotting insurers to obtain higher fees. See e.g., Puerto Rican Psychiatrists, C-3583, 60 Fed. Reg. 35,907 (July 12, 1995) (consent order) (Medical Association of Puerto Rico and its Psychiatry Section charged with conspiring to boycott a government insurance program to increase reimbursement rates); Michigan State Medical Society, 101 F.T.C. 191 (1983) (conspiracy to obstruct cost containment programs of Blue Cross/Blue Shield and Michigan Medicaid programs).

- * coercing hospitals into abandoning their efforts to introduce alternatives to traditional fee-for-service medicine, such as integrated multispecialty medical group practices, managed care plans, and hospital-owned primary care clinics. See e.g., Medical Staff of Doctors' Hospital of Prince George's County, 110 F.T.C. 476 (1988) (consent order) (medical staff charged with conspiracy to coerce owner of hospital to abandon plans to open an HMO facility in the area through threats of concerted action to "close" the hospital).
- * using the hospital staff credentialing process to block the development of managed care and non-physician practice.¹ See e.g., Medical Staff of Holy Cross Hospital, 114 F.T.C. 555 (1991) (consent order) (medical staff charged with conspiracy to obstruct development of the Cleveland Clinic's integrated multispecialty group medical practice).

These enforcement activities are significant examples of the Agencies' efforts to promote consumer welfare.

B. The Requirement that Activities Be Undertaken To Promote Quality Health Care Rather than Financial Gain Does Not Significantly Limit the Exemption

"Quality of care" is often raised as a justification for anticompetitive conduct by health care providers, and has been advanced to support, among other things, broad restraints on price competition, policies that inhibited the development of managed care organizations, and concerted refusals to deal with providers or organizations that represented a competitive threat to physicians. For example, the AMA maintained that its ethical prohibitions on contractual arrangements involving fees lower than those usual for the area, "underbidding" another physician, and reimbursement on a basis other than fee-for-service, were necessary to prevent impairment of the doctor's medical judgment, "commercialism" in medicine, and deterioration of medical care. American Medical Ass'n, 94 F.T.C. at 1011-12, 1017. Likewise, in Michigan State Medical Society, 101 F.T.C. 191, 294-95 (1983), the Society argued that its threats to boycott the Michigan Blue Cross/Blue Shield and Medicaid programs if its fee demands were not met were motivated by concern for the welfare of patients, because low reimbursement could lead to lower physician participation rates, forcing patients to seek less reputable providers.

¹ The proposed exemption would not apply if the activity "interferes with the provision of health care services by any health care provider who is not a member of the specific profession which is subject to the authority of the medical self-regulatory entity." Although this provision may limit the impact of the exemption on practice by providers who are not physicians, the exemption could still shield a broad range of activities, such as boycotts and price fixing, and may also shield medical self-regulatory actions that govern the conduct of physicians but indirectly impede practice by non-physician practitioners.

As a result, the harm that may be permitted by the proposed exemption is not limited significantly by the requirement that actions be taken to promote quality rather than financial gain. Indeed, an exemption for conduct "designed to promote the quality of health care services" could have the unintended effect of immunizing actions where an articulated quality goal was a pretext for, or coexisted with, a purpose to protect market participants from vigorous competition. Moreover, even if standard setters are acting in good faith, actions based on fundamentally flawed hypotheses about what is good for the marketplace, and actions that are much broader than reasonably necessary to accomplish a legitimate goal, can injure consumers just as much as those where quality claims are in fact a pretext. Past cases have often involved challenges to self-regulatory actions that were significantly overbroad. Finally, to the extent that the Agencies determined that an action was undertaken for financial gain, substantial Agency and court resources would likely have to be devoted to litigating over the parties' intentions, even when the effect of the conduct on consumers was plainly harmful.

The proposed exemption could permit a broad range of conduct harmful to consumers to escape the reach of the antitrust laws based on an assertion of quality concerns, without any review of the validity of those claims or the actual effect of the conduct. The record of antitrust enforcement in health care markets by the Agencies and others demonstrates the range of pernicious conduct that the proposed exemption could immunize.

C. The Exemption Is Not Needed To Protect Legitimate Professional Self-Regulatory Activity

A special antitrust exemption for physicians is not necessary to protect the public's interest in obtaining high-quality health care. Current law permits collective efforts by physicians and other health care providers to promote quality, provided that such efforts are properly circumscribed to achieve that purpose and thus do not unreasonably injure competition. Actions such as standard setting and certification, and more generally the publication of a professional group's opinion on issues affecting quality, do not restrain, and can in fact improve, the ability of consumers to choose among competing alternatives.

Thus, under prevailing law, medical organizations can and routinely do engage in technology assessment, risk management, and development and implementation of practice guidelines or practice parameters, activities that the proposed exemption is intended to protect. These activities are occurring now, and neither the Federal Trade Commission nor the Department of Justice has ever challenged such legitimate self-regulatory activity. Antitrust law already recognizes the right of competitors to engage in such conduct. What is forbidden under current antitrust law standards is for medical groups coercively to impose on the market their view of what consumers should want.

Likewise, the antitrust laws do not prohibit legitimate peer review activities. Several advisory opinions have approved peer review programs, including enforcement provisions to

protect consumers from fraud and similar abuse. See Commission Advisory Opinion to American Medical Association (February 14, 1994). Furthermore, to address concerns about private lawsuits challenging peer review activities, Congress in 1986 enacted the Health Care Quality Improvement Act, 42 U.S.C. § 11101 (1992), which eliminates private damage actions for good faith peer review that is undertaken with certain procedural safeguards.

The broad antitrust exemption that would be provided by H.R. 2425 is also not warranted as a response to possible concerns that uncertainty about the antitrust laws may be deterring beneficial self-regulatory conduct by physician organizations. As noted above, the types of legitimate activities that this proposed exemption seeks to immunize already are occurring. There is no apparent chilling of such activity due to uncertainty about the antitrust laws that would justify a broad exemption. Moreover, the Agencies have provided, and will continue to provide, guidance to those who desire to undertake such legitimate and procompetitive activity. We have done so through the issuance in 1993 and 1994 of joint Statements of Enforcement Policy and Analytical Principles Relating to Health Care and Antitrust, through numerous Commission and Commission staff advisory opinions and Department business review letters, and through a variety of less formal means.

D. The Exemption Would Undermine Efforts To Promote High Quality, Cost-Effective Health Care

Active antitrust enforcement against anticompetitive conduct by medical self-regulatory bodies has helped to remove obstacles to the development of the health care choices currently available to consumers. The proposed exemption, however, would allow physicians to impede the operation of existing providers and managed care plans in the market and to obstruct the development of new ones. Permitting medical self-regulatory entities to adopt and enforce standards without any effective check on the anticompetitive effects or possible abuse that such actions may create does not benefit consumers. Granting private medical organizations such power is likely to stifle innovation, retard progress in medicine, unnecessarily limit consumer choice, and frustrate cost containment efforts, both public and private.

While the exemption would not be limited to anticompetitive conduct related to the Medicare program, we note that it would also appear to undermine current Medicare reform efforts. It could permit medical societies or medical staffs to use the peer review process to discourage or prevent physicians from affiliating with certain managed care plans, including types of MedicarePlus organizations that are contemplated under H.R. 2425. Thus, for example, medical societies could take the position -- as they have in prior cases -- that HMOs or other managed care arrangements owned and operated by insurance companies or others who are not physicians do not meet the society's standards for "quality of care." Through its authority to conduct peer review of "professional conduct," a society could effectively discourage physicians from affiliating with such organizations. Such protected conduct could seriously undermine the

range of choices of MedicarePlus organizations available to Medicare recipients and discourage their enrollment in MedicarePlus managed care organizations.

II. SPECIAL ANTITRUST TREATMENT FOR PROVIDER SERVICE NETWORKS

Part 3 of Subtitle C of H.R. 2425, entitled "Special Antitrust Rule for Provider Service Networks," contains a provision that would exempt provider service networks ("PSNs") from the per se rule against price-fixing if the PSN met certain minimal criteria.² Specifically, Section 15021(a) provides that the conduct of a PSN or of its members in negotiating or performing a contract to provide services under a MedicarePlus PSO product³ "shall be judged on the basis of its reasonableness, taking into account all relevant factors affecting competition, including the effects on competition in properly defined markets." As discussed below, this provision would substantially relax the antitrust rules in the case of PSNs by exempting PSNs from the per se rule against price fixing that applies to competitors throughout the economy, and would undercut the bill's objective of using choice and competition to provide more cost-effective services to Medicare beneficiaries.

A. Current Antitrust Analysis Does Not Impede the Development of Cost-Effective Medicare Delivery Options

Antitrust's per se rule does not prohibit conduct that is likely to promote efficiency or benefit consumers. Per se treatment is reserved for "naked" restraints on competition: those that are inherently harmful to market forces without offering offsetting benefits. A clear example of such a restraint is an agreement among competitors to fix the price of the products or services they sell, when the agreement is not reasonably necessary to the operation of an efficiency-enhancing joint venture.

A special antitrust rule for PSNs is not necessary to allow provider groups to establish a provider-sponsored organization (PSO) under the Medicare Plus program, develop fee schedules

² A provider service network is an organization of providers that is funded in part by members' capital contributions; contracts on behalf of its members to provide services under the terms of a MedicarePlus product offered by a provider-sponsored organization ("PSO") and receives and distributes to its members compensation for such services; and has established quality and utilization review programs and a patient grievance and appeal program, all in conformity with MedicarePlus program rules for provider sponsored organizations. A provider service network may include a PSO. Section 15021(b)(6).

³ A MedicarePlus PSO product is a product offered by a provider-sponsored organization under other provisions of the bill.

for paying their participating providers, or set up provider panels. Under H.R. 2425, PSOs and other entities offering MedicarePlus products are required to assume full financial risk for the provision of all covered services, in exchange for a predetermined capitation payment.⁴ PSOs and other plan sponsors are economically integrated entities for purposes of the antitrust laws; as a result, under current antitrust law, conduct integral to their operation would be subject not to the per se rule of illegality, but to the more extensive competitive analysis of the "rule of reason."⁵ The risk-sharing required of PSOs appears integral to the purposes of the legislation, and reflects the importance of financial integration in ensuring that health care services are provided efficiently. When a provider group shares substantial financial risk, each member of the group has the incentive to assure that the group provides high-quality services in a cost-effective manner.

Unlike PSOs, however, PSNs that contract with a PSO would not be required to share financial risk in order for the PSN's members to avoid per se analysis when they collectively set the fees at which they will provide health care services through the PSO. Instead, under the proposed legislation, PSNs that meet certain criteria -- some of which may be useful adjuncts to financial integration, but none of which are substitutes for the sharing of substantial financial risk -- would be exempt from the per se rule against price-fixing.

B. The Special Antitrust Treatment for PSNs Threatens To Harm Competition for Both Medicare and Non-Medicare Services

The goal of promoting more cost-effective delivery of Medicare services would not be furthered by allowing groups of competing providers in a PSN who do not share substantial financial risk to agree on the prices they would demand from the PSO for treating patients under a MedicarePlus PSO contract, bargain collectively with the PSO, and threaten a boycott if the PSO did not accept the providers' terms.⁶ In such a case, even though the anticompetitive effect of the conduct is clear and no countervailing efficiencies are produced, the bill would require the antitrust agencies to conduct a resource-intensive analysis of the market under the rule of reason. Relaxing antitrust standards in this manner is inconsistent with the objectives of increasing Medicare delivery options and making the provision of Medicare services more cost-effective.

⁴ Section 1851(c), (d).

⁵ Section 1854(a)(3) states that when multiple providers comprise a PSO, they must be under common control or share "substantial financial risk."

⁶ The Commission and the Department have addressed similar situations in a number of cases. See, e.g., Physicians Group, Inc., C-3610 (consent order issued August 11, 1995); Southbank IPA, Inc., 114 F.T.C. 783 (1991).

The impact of the bill could also extend beyond PSOs to all MedicarePlus providers, and indeed to all managed care organizations operating in a particular market. By allowing competing providers to engage in collective pricing activities in the context of bargaining to provide services to a MedicarePlus PSO, the bill could have the unintended effect of dampening competition among those same providers for non-PSO business. Providers who agree on prices to be demanded of PSOs may implicitly agree to adhere to similar demands with other plans. Such agreements may be very difficult to detect and prosecute, but could cause serious harm to patients who are the ultimate consumers of health care services. Once competing providers come together to discuss, set, and negotiate the fees they will require for PSO business, the information they exchange and the understandings they reach would likely spill over into their dealings not only with other MedicarePlus organizations, but also with the vast array of organizations that provide health care benefits to non-Medicare patients.

In sum, the exemption from the per se standard in Section 15021(a) would cast aside the long-established principle of antitrust analysis that certain kinds of agreements among competitors, such as price-fixing agreements that are not ancillary to productive economic integration, are so likely to harm competition that they should be prohibited without an elaborate market inquiry. The provision would make it harder for the enforcement agencies to prosecute conduct by parties that can have serious anticompetitive effects. For these reasons, the bill could encourage providers to undertake courses of action that pose a danger to competition but do not increase the efficiency of the participants or of the PSOs with which they contract. Such a result can only be harmful to PSOs, to other organizations that deliver health care services, and ultimately to the public.

III. CONCLUSION

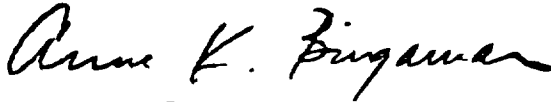
The Commission and the Department believe that the antitrust exemptions and special antitrust treatment for health care providers contained in H.R. 2425 are unnecessary and unjustified. The provisions would not serve the interests of consumers or the goals of H.R. 2425.

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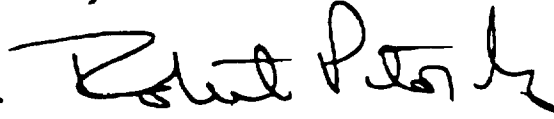
The Department of Justice has been advised by the Office of Management and Budget that there is no objection to the submission of this letter from the standpoint of the Administration's program.

Sincerely,

By direction of the Commission.



Anne K. Bingaman
Assistant Attorney General



Robert Pitofsky
Chairman